

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG212 3-11-57 et

01842

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Maryland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>Grantsville, Maryland</u>	
3. NAME OF DECEASED (Type or print) First <u>Lucinda</u> Middle <u>Figgie</u> Last <u>Durst</u>		4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Grantsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Henry Figgie</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Hisser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Henry L. Durst</u>		Address <u>Grantsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive failure</u> DUE TO (b) <u>Myocardial Disease</u> DUE TO (c) <u>Heart Disease Arteriosclerotic</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January, 1956</u> , to <u>Feb. 17, 1957</u> , that I last saw the deceased alive on <u>Feb. 4, 1957</u> , and that death occurred at <u>6:38</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ruth Peachey</u> M.D.		ADDRESS (Street, city or town, state) <u>Grantsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Ruth Peachey M.D.</u>		DATE SIGNED <u>Feb 17, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>	22d. LOCATION (City, town, or county) (State) <u>Grantsville Garrett Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald F. Newman</u>		ADDRESS <u>Grantsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>Feb 21 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form 10-57

PLACE OF BIRTH STATE OF MARYLAND		DECEASED NAME	
DATE OF BIRTH JANUARY 1, 1900		SEX MALE	
PLACE OF DEATH BALTIMORE, MARYLAND		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH FEBRUARY 1, 1957		TIME OF DEATH 10:00 AM	
PLACE OF INTERMENT BALTIMORE, MARYLAND		NAME OF FUNERAL HOME BALTIMORE, MARYLAND	
NAME OF PHYSICIAN BALTIMORE, MARYLAND		NAME OF PATHOLOGIST BALTIMORE, MARYLAND	
NAME OF CORONER BALTIMORE, MARYLAND		NAME OF MEDICAL EXAMINER BALTIMORE, MARYLAND	
NAME OF NERVOUS SYSTEM BALTIMORE, MARYLAND		NAME OF RESPIRATORY SYSTEM BALTIMORE, MARYLAND	
NAME OF CIRCULATORY SYSTEM BALTIMORE, MARYLAND		NAME OF DIGESTIVE SYSTEM BALTIMORE, MARYLAND	
NAME OF URINARY SYSTEM BALTIMORE, MARYLAND		NAME OF REPRODUCTIVE SYSTEM BALTIMORE, MARYLAND	
NAME OF SKIN BALTIMORE, MARYLAND		NAME OF BONES BALTIMORE, MARYLAND	
NAME OF MUSCLES BALTIMORE, MARYLAND		NAME OF NERVES BALTIMORE, MARYLAND	
NAME OF BLOOD BALTIMORE, MARYLAND		NAME OF LYMPH BALTIMORE, MARYLAND	
NAME OF OTHER BALTIMORE, MARYLAND		NAME OF OTHER BALTIMORE, MARYLAND	

BUREAU V. 3

FEB 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01843/

1828

CERTIFICATE OF DEATH

Reg. Dist. No.

766

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EVANS NURSING HOME				e. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) CLARA First Middle Last				4. DATE OF DEATH FEB-7-1957 Month Day Year			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN-16-1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GRANTSVILLE	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME HENRY YOST			
14. MOTHER'S MAIDEN NAME SARAH LIVENGOOD				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT MRS. THELMA GLOTFELTY Address Accident MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infirmary 7 age 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Art. C. V. D. - Epilepsy							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Dec 29 1956 to Dec 29 1956 , that I last saw the deceased alive on Dec 29 1956 , and that death occurred at 3 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Lusby M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 2/8/57			
PHYSICIAN'S NAME (Type) THOMAS F. LUSBY M.D. Oakland, Md				22a. REC'D BY REGISTRAR 2/11/57 24. REGISTRAR'S SIGNATURE PR			
22b. DATE THEREOF FEB-9-1957		22c. NAME OF CEMETERY OR CREMATORY ACCIDENT CEMETERY		22d. LOCATION (City, town, or county) (State) Accident MD		23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS OAKLAND MD	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. HENRY		45		M		W		1912		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
FEB 28 1957		NEW YORK		NEW YORK		NEW YORK		FEB 28 1957		NEW YORK		NEW YORK		NEW YORK	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL		CATHOLIC		MARRIED		MARRIED		MARRIED	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF DEATH REGISTRAR	
JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY	

BUREAU V. B.

FEB 28 1957

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INSTRUCTIONS

TO A VANDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01844

CERTIFICATE OF DEATH

1829

Reg. Dist. No. 172

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		STATE MARYLAND		STATE W.VA.		COUNTY MINERAL	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN KITZMILLER		LENGTH OF STAY (in this place) 2 months		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Elk Garden 85X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS W. MAIN STREET				STREET ADDRESS (If rural give location) ORPHANS HOME SECTION			
3. NAME OF DECEASED (Type or Print) MAUDE LEE HOTT				4. DATE OF DEATH (Month) (Day) (Year) FEB. 6, 1957			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 12, 1885	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Housework)		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WILLIAMSPORT, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM LEWIS ROTRUCK				14. MOTHER'S MAIDEN NAME MARTHA JANE RODERICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS. LENA TURNER, KITZMILLER, Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) Acute obstruction of bowels						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of caecum and transverse colon							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Carcinoma of caecum & transverse colon				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 1, 1956 , to Feb. 6, 1957 , that I last saw the deceased alive on Feb. 6, 1957 , and that death occurred at 12:45 PM from the causes and on the date stated above.							
SIGNATURE Ralph Colandrella		M.D. Kitzmillers, Md		ADDRESS (Street, city, town, state) Elk Garden, Mineral Co, W.Va		DATE SIGNED Feb. 7-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/ 8/57		NAME OF CEMETERY OR CREMATORY Kalbaugh Cemetery		LOCATION (City, town, or county) (State) Elk Garden, Mineral Co, W.Va	
24. REC'D BY REGISTRAR DATE 2/7/57		REGISTRAR'S SIGNATURE UW Barack		25. FUNERAL DIRECTOR'S SIGNATURE O A Sharpless ADDRESS Blaine, W.Va.			

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. SEX		3. AGE	
HOME		MALE		40	
4. OCCUPATION		5. MARITAL STATUS		6. DATE OF DEATH	
LABORER		MARRIED		APRIL 12, 1957	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BURIAL	
HEART DISEASE		NATURAL		CATHOLIC CHURCH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signatures]	

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to investigation.

2. The cause of death should be stated in as simple and direct terms as possible, using the words "heart disease," "cancer," "pneumonia," etc., when appropriate. Do not use "old age" or "natural causes" unless you are sure of the cause.

3. The manner of death should be stated as "natural," "accident," "suicide," or "homicide." If the death was due to a disease or injury, it is usually "natural." If it was due to an accident, it is "accident." If it was due to self-inflicted injury, it is "suicide." If it was due to the action of another person, it is "homicide."

4. The place of death should be stated as "home," "hospital," "nursing home," "prison," etc.

5. The date of death should be stated in full, including the day, month, and year.

6. The occupation, marital status, and place of burial should be stated as accurately as possible.

7. The signature of the physician or other qualified person is required. If the death was certified by a coroner or medical examiner, his signature is required instead of the physician's.

8. The signature of the registrar is required. He is the official who registers the death and issues the death certificate.

9. The signature of two witnesses is required. They should be persons who were present at the death or who knew the deceased well.

BUREAU V. 2

FEB 13 1957

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6/2/57

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INSTRUCTIONS

TO A **REGISTERING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01845

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>GARRETT</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL GRANTSVILLE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>GARRETT</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL GRANTSVILLE</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>VERNON</u> (Middle) <u>RAY</u> (Last) <u>MCCOY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 9</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG 16 1922</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCTION FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HARRISON-WALKER</u>	9. AGE last birthday <u>34</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>TEMPLETON, PA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>CHARLES MCCOY</u>		14. MOTHER'S MAIDEN NAME <u>EDNA SWARTZWELDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>185-18-5151</u>	17. INFORMANT & ADDRESS <u>Mrs Dorothy McCoy - Grantsville Md</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
416X IMMEDIATE CAUSE (A) <u>Pulmonary embolism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instantly</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arricular fibrillation</u>			<u>2 mos</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Rheumatic heart disease</u>			<u>10 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 17, 1957</u> , to <u>Feb 9, 1957</u> , that I last saw the deceased alive on <u>Feb 9, 1957</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>A. Paige Strong</u> M.D.		ADDRESS (Street, city, town, state) <u>Salisbury Pa</u>	
DATE SIGNED <u>2/10/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>2/12/57</u>	NAME OF CEMETERY OR CREMATORY <u>Cochran</u>	LOCATION (City, town, or county) (State) <u>Templeton, Armstrong Co Pa</u>
24. REC'D BY REGISTRAR <u>W. Leach</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard J. Newman - Grantsville Md</u>	
DATE <u>FEB 13 '57</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED

1253

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF REBIRTH

34. SIGNATURE OF RESURRECTION

35. SIGNATURE OF JUDGMENT

36. SIGNATURE OF GLORY

37. SIGNATURE OF HONOR

38. SIGNATURE OF WEALTH

39. SIGNATURE OF POWER

40. SIGNATURE OF KNOWLEDGE

41. SIGNATURE OF WISDOM

42. SIGNATURE OF FAITH

43. SIGNATURE OF HOPE

44. SIGNATURE OF CHARITY

45. SIGNATURE OF LOVE

46. SIGNATURE OF MERCY

47. SIGNATURE OF GRACE

48. SIGNATURE OF PEACE

49. SIGNATURE OF JOY

50. SIGNATURE OF BLISS

51. SIGNATURE OF HAPPINESS

52. SIGNATURE OF CONTENTMENT

53. SIGNATURE OF SATISFACTION

54. SIGNATURE OF WELL-BEING

55. SIGNATURE OF HEALTH

56. SIGNATURE OF STRENGTH

57. SIGNATURE OF VIGOR

58. SIGNATURE OF ENERGY

59. SIGNATURE OF DYNAMISM

60. SIGNATURE OF ACTION

61. SIGNATURE OF DEED

62. SIGNATURE OF WORK

63. SIGNATURE OF EFFORT

64. SIGNATURE OF STRUGGLE

65. SIGNATURE OF BATTLE

66. SIGNATURE OF WAR

67. SIGNATURE OF CONFLICT

68. SIGNATURE OF TROUBLE

69. SIGNATURE OF DIFFICULTY

70. SIGNATURE OF PROBLEM

71. SIGNATURE OF OBSTACLE

72. SIGNATURE OF HINDRANCE

73. SIGNATURE OF IMPEDIMENT

74. SIGNATURE OF BARRIER

75. SIGNATURE OF WALL

76. SIGNATURE OF FENCE

77. SIGNATURE OF GATE

78. SIGNATURE OF DOOR

79. SIGNATURE OF WINDOW

80. SIGNATURE OF HOLE

81. SIGNATURE OF CRACK

82. SIGNATURE OF BREACH

83. SIGNATURE OF GAP

84. SIGNATURE OF SPLIT

85. SIGNATURE OF FISSURE

86. SIGNATURE OF CLEFT

87. SIGNATURE OF CREVICE

88. SIGNATURE OF CRACKLE

89. SIGNATURE OF CRASH

90. SIGNATURE OF COLLAPSE

91. SIGNATURE OF RUIN

92. SIGNATURE OF DESTRUCTION

93. SIGNATURE OF ANNIHILATION

94. SIGNATURE OF DESTRUCTION

95. SIGNATURE OF DESTRUCTION

96. SIGNATURE OF DESTRUCTION

97. SIGNATURE OF DESTRUCTION

98. SIGNATURE OF DESTRUCTION

99. SIGNATURE OF DESTRUCTION

100. SIGNATURE OF DESTRUCTION

BUREAU V. 8

FEB 13 1957

RECEIVED

1831

CERTIFICATE OF DEATH

02946

Reg. Dist. No. 766

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Highlands			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,				c. LENGTH OF STAY IN 1b 3 Mo.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sebring 48X-3				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. Third St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Resley Middle Carr Last Rush				4. DATE OF DEATH Month February Day 24 , Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1867	9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Groceries		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Rush				14. MOTHER'S MAIDEN NAME Sabina Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Vernie R. Smouse Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4 hours 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 28 Nov. 1956 to 24 Feb. 1957 , that I last saw the deceased alive on 24 Feb. 1957 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. E. Mance				ADDRESS (Street, city or town, state) Oakland Md.		DATE SIGNED 25 Feb 57	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/1957		22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery		22d. LOCATION (City, town, or county) (State) near Friendsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 2/27/1957	
				24b. REGISTRAR'S SIGNATURE Julian R. Ryan			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G212 3-18-57 et

1832

CERTIFICATE OF DEATH

Reg. Dist. No.

01846
66

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO OAKLAND MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EVANS NURSING HOME		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) ELLA ELIZABETH SISLER.		4. DATE OF DEATH FEB - 11 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT.-4-1884
9. AGE (In years last birthday) 72 7/8 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NEAR RED HOUSE	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY SISLER		14. MOTHER'S MAIDEN NAME CHESTINA FIKE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 0	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senescent Heart Disease DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 5 days 7 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec , 19 48 , to 2-11 , 19 57 , that I last saw the deceased alive on 2-11 , 19 57 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Jester		ADDRESS (Street, city or town, state) 58 2nd St Oakland MD	
DATE SIGNED 2-12-57			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB-13-1957	
22c. NAME OF CEMETERY OR CREMATORY WOLF CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR RED HOUSE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden		ADDRESS OAKLAND MD	
24a. REC'D BY REGISTRAR 2/13/57		24b. REGISTRAR'S SIGNATURE J. H. Jester	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

GARRITT		MID	
CARLAND		MID	
ELLA		ELIZABETH SISTER	
FEMALE WHITE		OCT-4-1924	
ROOSEWITE		NEAR RED HOUSE	
HENRY SISTER		CHESTINA LIKE	

BUREAU V. S.

1957 15 15

RECEIVED

BURIAL FEBRUARY 1957 NEAR RED HOUSE CARLAND MID

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G211 2-25-57 et

CERTIFICATE OF DEATH

01847

Reg. Dist. No. 66

1833

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Harrison	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 1/2 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppitt Rest Home		d. STREET ADDRESS 85X-3	
3. NAME OF DECEASED (Type or print) First Louis Middle - Last Smith		4. DATE OF DEATH Month 2 Day 3 Year 19 57	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-83
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months 1 Days 29 Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 236-09-7049	
17. INFORMANT Mrs. Maymie Willis, Shinnston, W.Va.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Rt. Lung - 163X DUE TO Advanced, Inoperable Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO - (c) -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-2-57 19, to 2-3-57 19, that I last saw the deceased alive on 2-2-57 19, and that death occurred at 7:00 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, W.Va. DATE SIGNED 2/4/57			
ACTUAL SIGNATURE Thomas F. Lusby M.D.		PHYSICIAN'S NAME (Type) THOMAS F. LUSBY M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-57	
22c. NAME OF CEMETERY OR CREMATORY Shinnston, Masonic		22d. LOCATION (City, town, or county) (State) Shinnston, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Strick		24a. REC'D BY REGISTRAR Julia Rower 24b. REGISTRAR'S SIGNATURE PR	

4001 2-8

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01848

Item 7 FilmG210 2-18-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle William Last Swauger		4. DATE OF DEATH Month February Day 9 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Separated WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1886
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Woodsman		10b. KIND OF BUSINESS OR INDUSTRY CUTTING TIMBER	
11. BIRTHPLACE (State or foreign country) New Germany, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaac Swauger		14. MOTHER'S MAIDEN NAME Virginia Layman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 167-14-8011	
17. INFORMANT MRS NELLIE WARNICK		Address GRANTSVILLE, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. Irving Baumgartner		DATE SIGNED 2/9/57	
EXAMINER'S NAME (Type) E. Irving Baumgartner, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/12/57	22c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE	22d. LOCATION (City, town, or county) (State) GRANTSVILLE, GARRETT CO, MD
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman, Grantsville, Md.		24a. REC'D BY REGISTRAR FEB 13 57	24b. REGISTRAR'S SIGNATURE W. Leach

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the office of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VENDOR		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF BURIAL		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
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76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
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82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
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88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
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94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED
JUL 13 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01849

1835

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville Md RD		c. LENGTH OF STAY IN 1b 51 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAFAYETTE First Middle Last UPHOLD		4. DATE OF DEATH Month 2 Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR-15-1920
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		10b. KIND OF BUSINESS OR INDUSTRY Co-Road	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Franklin Uphold		14. MOTHER'S MAIDEN NAME Martha Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Mabel Revokde		Address RT 4-536 Alexandria - Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 12, 1946 , to Feb 14, 1957 , that I last saw the deceased alive on Feb 7, 1957 , and that death occurred at 8:59 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Friendsville, Maryland. February 15, 1957			
ACTUAL SIGNATURE Milton Tepfer M.D.		PHYSICIAN'S NAME (Type) Milton Tepfer, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 17 1957	
22c. NAME OF CEMETERY OR CREMATORY Bloomington Cem.		22d. LOCATION (City, town, or county) (State) Friendsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Rodakauer - Markleysburg Pa		24a. REC'D BY REGISTRAR DATE 2-16-57	
24b. REGISTRAR'S SIGNATURE Mrs. Ruth Frantz		Dep.	

Re: *John Doe - Plaintiff*

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01850

Reg. Dist. No. 172

1. PLACE OF DEATH COUNTY Garrett CITY (If outside corporate limits, write RURAL OR TOWN) Kitzmiller HOSPITAL OR INSTITUTION OR STREET ADDRESS Homestead Street				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Garrett CITY (If outside corporate limits, write RURAL and give nearest town) Kitzmiller STREET ADDRESS (If rural give location) Homestead Street			
3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) JANE (Last) WHITACRE				4. DATE (Month) (Day) (Year) OF DEATH FEB. 19, 1957			
5. SEX Female	6. COLOR OR White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Widowed	8. DATE OF BIRTH March 16, 1870	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housework		Own Home		Garrett Co., Md.		U.S.A.	
13. FATHER'S NAME Lewis Francis Harvey				14. MOTHER'S MAIDEN NAME Melissa Harvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Truman Whitacre, Kitzmiller, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 4222 Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSE(S) DUE TO (B) Arricular fibrillation				4 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Myocardial degeneration				Unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Uremia				3-4 days			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from One week , 19 57 , to Feb. 18 , 19 57 , that I last saw the deceased alive on Feb. 18 , 19 57 , and that death occurred at 7:55 A.M. the causes and on the date stated above.							
SIGNATURE Hubert H. Leighton		M.D.		ADDRESS (Street, city, town, state) 77 Oak St., Oakland Md.		DATE SIGNED Feb. 20, 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/22/57		NAME OF CEMETERY OR CREMATORY Hamill Cemetery		LOCATION (City, town, or county) (State) Kitzmiller, Md.	
24. REC'D BY REGISTRAR DATE 2/21/57		REGISTRAR'S SIGNATURE AWB		25. FUNERAL DIRECTOR'S SIGNATURE B. H. Shortless		ADDRESS Blaine, W. Va	

CERTIFICATE OF DEATH

11832

1. CAUSE OF DEATH (NOMENCLATURE OF DISEASE)

Heart failure

2. PLACE OF DEATH

Home

3. DATE OF DEATH

November 15, 1950

4. TIME OF DEATH

10:30 P.M.

5. SEX

Male

6. AGE

65

7. OCCUPATION

Garment Co., Inc.

8. MARITAL STATUS

Married

9. NAME OF DECEASED

Thomas W. Winters, Jr.

10. NAME OF NEXT OF KIN

Thomas W. Winters, Jr.

11. NAME OF PHYSICIAN

Dr. W. W. Winters

12. NAME OF BURIAL PLACE

Home

13. NAME OF FUNERAL HOME

Home

14. NAME OF CEMETERY

Home

15. NAME OF INTERVIEWER

Home

16. NAME OF WITNESS

Home

17. NAME OF SIGNER

Home

18. NAME OF OFFICIAL

Home

19. NAME OF CLERK

Home

20. NAME OF ASSISTANT

Home

21. NAME OF ATTENDING PHYSICIAN

Home

22. NAME OF SURGEON

Home

2. PLACE OF DEATH

Home

3. DATE OF DEATH

November 15, 1950

4. TIME OF DEATH

10:30 P.M.

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12. NAME OF BURIAL PLACE

Home

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Home

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Home

15. NAME OF INTERVIEWER

Home

16. NAME OF WITNESS

Home

17. NAME OF SIGNER

Home

18. NAME OF OFFICIAL

Home

19. NAME OF CLERK

Home

20. NAME OF ASSISTANT

Home

21. NAME OF ATTENDING PHYSICIAN

Home

22. NAME OF SURGEON

Home

23. NAME OF CLERK

Home

RECEIVED
FEB 25 1957
BUREAU V. E.